CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

The Commonwealth of Massachusetts
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Department of Public Health
Bureau of Health Professions Licensure
Drug Control Program
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MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Massachusetts Controlled Substance Registration (MCSR) Termination Form

Registrant Information

MCSR number: Expiration Date:

Registrant Name:

Email Address:

Address:
No. Street City State/Country Zip/Postal Code

Please select the reason(s) for terminating your MCSR:

☐ Addition of MCSR drug schedules*
☐ Change of MCSR business address*
☐ Retiring
☐ Terminated, revoked, voided by process of law or regulation
☐ Going out of business
☐ Other, please describe:

***** If you wish to add additional drug schedules or change your business address, you must apply for a new MCSR. We recommend applying for a new MCSR before terminating your existing MCSR.

Please review and complete as appropriate

1. I understand that my Massachusetts Controlled Substances Registration (MCSR) has been willingly terminated by me, or has been terminated or revoked, has become void due to process of law or regulation.

2. I understand that I am no longer authorized to prescribe, purchase, order, store, or administer controlled substances as part of a professional practice or research study in the Commonwealth of Massachusetts associated with this MCSR.

3. I hereby certify that I have destroyed my MCSR that I am terminating with this form.
4. I hereby affirm that I am no longer prescribing, ordering, storing, administering controlled substances associated with this MCSR and/or the business has closed effective _____ and (please check one of the below, as appropriate):
Date

☐ I have no controlled substances in my possession, custody or control pursuant to my former MCSR

☐ I have attached a copy of my disposition plan showing appropriate legal disposition of the controlled substances which were in my possession, custody or control pursuant to my former professional practice.

☐ I have applied for and received a new MCSR with the appropriate drug schedules and business address. The new MCSR # is: _____

I hereby certify that, under pains and penalties of perjury, all of the information submitted in this form, and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this form is grounds for MCSR revocation or denial of the MCSR and may subject me to civil or criminal penalties. My signature on this MCSR form attests under penalties of perjury that, to the best of my knowledge and belief, I have complied with: state tax and child support laws M.G.L. c. 62C, section 49A); and the laws of the commonwealth of Massachusetts and all applicable rules and regulations of the Department of Public Health and the Drug Control Program.

_____ _____
Signature Date

Please submit your Termination Form via email, fax, or mail:

Email: MCSR@massmail.state.ma.us

Fax: 617-753-8233

Mail: Bureau of Health Professions Licensure
Drug Control Program, Attn: MCSR
239 Causeway Street, 5th Floor Suite 500
Boston, MA 02114